2013 BENEFITS AT A GLANCE

In-Network Benefits	COVA Care You Pay	COVA HealthAware* You Pay	Kaiser Permanente You Pay	COVA HDHP You Pay
Deductible – per plan year				
▪One person	$225	$1,500	None	$1,750
▪Two or more persons	$450	$3,000	None	$3,500
Out-of-pocket expense limit – per plan year				
▪One person	$1,500	$3,000	$1,500	$5,000
▪Two or more persons	$3,000	$6,000	$3,000	$10,000
Doctor's visits				
▪Primary care physician	$25	20% after deductible	$25	20% after deductible
▪Specialist	$40	20% after deductible	$40	20% after deductible
Hospital services				
▪Inpatient	$300 per stay	20% after deductible	$300 per admission	20% after deductible
▪Outpatient	$125 per visit	20% after deductible	$75 per visit	20% after deductible
Emergency room visits	$150 per visit (waived if admitted)	20% after deductible	$75 per visit (waived if admitted)	20% after deductible
Ambulance travel	20% after deductible	20% after deductible	$50 per service	20% after deductible
Outpatient diagnostic, laboratory, tests, shots and x-rays	20% after deductible	20% after deductible	$0 lab, pathology, shots radiology, diagnostic tests $75 specialty imaging	20% after deductible
Infusion services (includes IV or injected chemotherapy)	20% after deductible	20% after deductible	$25 PCP $40 specialty	20% after deductible
Outpatient therapy visits				
▪Occupational, physical and speech therapy	$25 PCP/$35 specialist	20% after deductible	$40	20% after deductible
▪Chiropractic (30-visit plan year limit per member)	$35	20% after deductible	$40	20% after deductible
Applied behavior analysis (ABA) for autism spectrum disorder—ages 2 through 6 ▪$35,000 annual limit	$25 per service	20% after deductible	$25 per visit	20% after deductible
Behavioral health visits	$25	20% after deductible	$12 group therapy $25 individual therapy	20% after deductible
Employee Assistance Program (EAP) Up to 4 visits per incident	$0	$0	$0	$0
Prescription drugs – mandatory generic				
Retail Pharmacy	*Up to 34-day supply* $15/$25/$40/$50	*Up to 34-day supply* 20% after deductible	*Up to 30-day supply* Medical center: $15/$25/$40 Community participating: $20/$45/$60 (3 x copayment for 90 days)	*Up to 34-day supply* 20% after deductible
Home Delivery Pharmacy	*Up to 90-day supply* $30/$50/$80/$100	*Up to 90-day supply* 20% after deductible	*Up to 30-day supply* $13/$23/$38 (2 x copayment for 90 days)	*Up to 90-day supply* 20% after deductible
Dental Services				
▪Diagnostic and preventive	$0	$0	See fee schedule	$0
Annual Routine Vision Exam	Not available	$0	Not available	Not available
Annual Routine Hearing Exam	Not available	$0	Not available	Not available
Wellness & preventive services	$0	$0	$0	$0
Birth to 18 years	*Office visits at specified intervals, immunizations, lab and x-rays*			
	Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays			
19 years and older	*Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening*			

*Includes an HRA fund of $600 for an employee and $1,200 for an employee and spouse to help pay family out-of-pocket costs.

2013 BENEFITS AT A GLANCE

In-Network Benefits	COVA Care You Pay	COVA HealthAware You Pay	Kaiser Permanente You Pay	COVA HDHP You Pay
Expanded Dental	*Optional Benefit*:*	*Optional Benefit*:*		*Optional Benefit*:*
▪Maximum benefit – per member	$2,000	$2,000	$1,000	$2,000
▪Deductible	$50/$100/$150	$50/$100/$150	$25 per person	$50/$100/$150
▪Primary (basic) care	20% after deductible	20% after deductible	See fee schedule	20% after deductible
•Complex restorative (inlays, onlays, crowns, dentures, bridgework)	50% after deductible	50% after deductible	See fee schedule	50% after deductible
•Orthodontic	50% no deductible	50% no deductible	See fee schedule	50% no deductible
--Lifetime maximum benefit	$2,000	$2,000	$1,000 (age 19 and under)	$2,000
Routine Vision (*once every plan year*)	*Optional Benefit* :*	*Optional Benefit*:*		Not available
•Routine eye exam	$40	Included in basic plan	$25 PCP/$40 specialist	
•Eyeglass frames	20% off balance after plan pays first $100	20% off balance after plan pays first $100	25% discount	
•Lenses				
--Eyeglass lenses (*standard plastic, single, bifocal or trifocal*) or	$20	$20	25% discount	
--Contact lenses –				
•Conventional** or disposable**	15% off balance after plan pays $100	15% off balance after plan pays $100	15% discount off initial fitting and pair	
•Non-elective**	Balance after plan pays $250	Balance after plan pays $250	15% discount off initial fitting and pair	
Routine Hearing (*once every 48 months)*	*Optional Benefit*:*	Included in basic plan		Not available
•Routine hearing exam	$40		$25 PCP/$40 specialist	
•Hearing aids and other hearing-aid related services	Balance after plan pays $1,200	Not available	Not available	Not available
•Benefit maximum	$1,200			
Out-of-Network	*Optional Benefit*:* Plan payment reduced by 25%. Provider may balance bill for amount above allowable charge.	Additional deductible out-of-pocket limits apply. 40% coinsurance after deductible. Provider may balance bill for amount above allowable charge.	Not available	Not available

*Options are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart.
**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

This is only an overview of your health care benefits. For details, see the appropriate Member Handbook or plan document, or www.dhrm.virginia.gov.

The program also offers the TRICARE voluntary supplement, which coordinates with federal TRICARE benefits.